APPENDIX B (AP 3-12)

AUTHORIZATION OF ADMINISTRATION OF ORAL/TOPICAL MEDICATION

TO BE COMPLETED BY PARENT/GUARDIAN

Name of Student			
Birthdate		**Grade**	
Address			
Postal Code		**Telephone**	
Parent's/Guardian's Name			
Business Address			
Postal Code		**Telephone**	

PARENT/GUARDIAN APPROVAL

I hereby request and give permission to {Name of School} _____ to administer Oral/topical medication to my child according to School DSBN procedures and the instructions of the Physician. I also affirm that the medication provided is the medication stated on the container provided to the school.

Signature of Parent/Guardian: _____ Date: _____

TO BE COMPLETED BY PHYSICIAN

Condition of Patient for which Oral/Topical Medication is Necessary	
Name of Medication	
Dosage or Amount to be Given Each Time	· As Indicated on Prescription Label
What Time(s) Dosage to be Given	· As Indicated on Prescription Label
Method of Administration (with Food?)	
Possible Side Effects	
Storage and Safekeeping Requirements for Medication	
Prescribing Physician's Name {Please Print}	
Office Address and Telephone Number	

Signature of Physician:_____ Date:_____